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No. 07-791

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IN THE

# Supreme Court of the United States

JAMES A. SHANK, AS TRUSTEE OF THE DEBORAH J. SHANK IRREVOCABLE TRUST, DEBORAH J. SHANK, AND THE DEBORAH J. SHANK IRREVOCABLE TRUST,

*Petitioners*,

v.

ADMINISTRATIVE COMMITTEE OF THE WAL-MART STORES, INC. ASSOCIATES' HEALTH AND WELFARE PLAN,

*Respondent*.

**On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit**

## BRIEF IN OPPOSITION

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## QUESTION PRESENTED

Whether federal courts should impose a rule of federal common law based on the "make whole" or "pro rata" doctrines to limit an ERISA plan's right to reimbursement of benefits paid by the plan in the event of a participant's recovery from a third party despite unambiguous and undisputed plan language requiring full reimbursement.

## PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all of the parties to the proceeding. Wal-Mart Stores, Inc., a publicly traded company, sponsors the self-funded Wal-Mart Stores, Inc. Associates' Health and Welfare Plan (the "Plan") within the meaning of ERISA, 29 U.S.C. § 1002(1). The Plan is not publicly-traded, has no parent corporation, and no publicly-held company owns 10% or more of the Plan's stock. Wal-Mart Stores, Inc. has no parent corporation, and no publicly-held company owns 10% or more of its stock.

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## BRIEF IN OPPOSITION

## OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-12a) is reported at 500 F.3d 834. The opinion of the district court (Pet. App. 13a-26a) is unofficially reported at 2006 WL 2546797.

## JURISDICTION

The judgment of the court of appeals was entered on August 31, 2007. A petition for rehearing en banc was denied on October 29, 2007. Petitioners have invoked the jurisdiction of this Court pursuant to 28 U.S.C. § 1254(1).

## STATUTORY PROVISION INVOLVED

Section 502(a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(3), provides:

> A civil action may be brought by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

## STATEMENT

1. Deborah J. Shank ("Petitioner") was a Wal-Mart employee and a member of the Associates' Health and Welfare Plan, Wal-Mart's self-funded employee benefit plan regulated by ERISA. The Plan provides that, in the event of an accident:

> The Plan has the right to . . . recover or subrogate 100 percent of the benefits paid by the Plan on your behalf . . . to the extent of . . . [a]ny judgment, settlement, or any payment made or to be made, relating to the accident . . . . These rights apply regardless of whether such payments are designated as payment for . . . [m]edical benefits [or] [w]hether the participant has been made whole (i.e., fully compensated for his/her injuries). . . . The Plan has first priority with respect to its right to reduction, reimbursement and subrogation.

Pet. App. at 8a.

On May 12, 2000, Petitioner was injured in a car accident. In accordance with the terms of the Plan, and though Petitioner had been a participant in the Plan for just over three months, the Administrative Committee of the Wal-Mart Associates' Health and Welfare Plan (the "Committee") paid the full amount of Petitioner's medical expenses in connection with the accident, a total of $469,216. Petitioner filed a lawsuit against the parties responsible for the accident and obtained a settlement of $700,000. After attorneys' fees and costs were deducted, the remaining $417,477 was placed in a special needs trust for the benefit of Petitioner.

Though the Committee repeatedly advised Petitioner of her obligation to reimburse the Plan from any settlement she obtained and her duty to notify the Plan before settlement, it did not learn of Petitioner's settlement until after the proceeds from the settlement had already been placed in the trust.

Because Petitioner did not reimburse the Plan, the Committee, as the named fiduciary of the Plan, was compelled to bring suit in federal district court under section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), to enforce the Plan's terms and seek reimbursement for benefits the Plan paid on Petitioner's behalf.

2. The district court granted summary judgment to the Committee because the terms of the Plan "unambiguously give[ ] the Plan first priority with respect to its right to reimbursement and subrogation from the proceeds of a settlement received for injuries incurred for which the Plan paid benefits." Pet. App. 24a. In accordance with this Court's decisions in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), and *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S. Ct. 1869 (2006), the district court placed a constructive trust on the special needs trust in an amount not to exceed $469,216, the undisputed amount paid by the Plan for Petitioner's medical bills as a result of the accident.

3. Petitioner appealed the district court's judgment, arguing that, despite the Plan's clear language requiring Petitioner to reimburse the Committee in full for medical expenses paid on her behalf, full reimbursement was not "appropriate equitable relief" pursuant to section 502(a)(3) of ERISA. The court of appeals reviewed the district court's decision *de novo* and, keeping with the decisions of its sister circuits, affirmed in a unanimous opinion.

Applying this Court's decision in *Sereboff*, the court of appeals held that

> the Committee's claim [met] *Sereboff*'s requirements for equitable restitution

> [because] it [sought] (1) the specific funds it is owed under the terms of the plan—i.e., the money it paid to cover [Petitioner's] medical expenses; (2) from a specifically identifiable fund that is distinct from the Shank's general assets—i.e., the special needs trust; and (3) that is controlled by defendant James Shank, the trustee.

Pet. App. at 4a-5a. Petitioner does not challenge or seek review of this holding in this Court.

The court rejected Petitioner's argument that full reimbursement was not "appropriate" under section 502(a)(3) because Petitioner had not been "made whole" by the settlement she received. Pet. App. at 6a. Petitioner had urged the court to construct a "rule of federal common law" applying the "make-whole" or "pro rata" doctrine to override the Plan's explicit language requiring full reimbursement. *Id.* at 5a. Under the "make whole" doctrine adopted by some state courts in the insurance context, an insurer is not allowed to enforce a contractual right to reimbursement unless the insured is first "made whole," i.e., fully compensated for all her injuries. *See* 16 LEE R. RUSS ET AL., COUCH ON INSURANCE § 223:134 (3d ed. 2005). Similarly, the "pro rata" doctrine dictates that the insurer receive only partial reimbursement proportionate to the share of the insured's settlement that compensates her for medical expenses. *See CNA Ins. Cos. v. Johnson Galleries*, 639 So. 2d 1355, 1359 (Ala. 1994).

In reaching its decision, the court cited the consensus among the courts of appeals that common law theories must not be applied to "alter the express terms of a written plan." Pet. App. at 6a-7a. It

reasoned that "[n]othing in the statute suggests Congress intended that section 502(a)(3)'s limitation of the Committee's recovery to 'appropriate equitable relief' would upset . . . contractually-defined expectations." *Id.* at 10a. Noting this Court's holding that ERISA's "repeatedly emphasized purpose [is] to protect *contractually defined* benefits," *id.* at 9a (citing *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)), the court rejected Petitioner's assertion that the "make-whole" and "pro rata" doctrines should trump the written ERISA Plan, Pet. App. at 11a.

Petitioner then sought rehearing en banc, reiterating the same arguments she made before the panel. The Eighth Circuit denied the petition.

## REASONS FOR DENYING THE PETITION

Petitioner contends that certiorari is appropriate to address whether the "make whole" or "pro rata" doctrine should be applied as an exercise of federal common lawmaking to contravene the clear language of a written ERISA plan. But certiorari is unwarranted for three reasons. First, though Petitioner attempts to portray this question as one of first impression, Petitioner's argument has been considered and rejected decisively and consistently by the courts of appeals. Not only is there no conflict among the lower courts on this question, but the decision of the Eighth Circuit below is consistent with the decisions of ten other circuits—every circuit to have considered the issue.[1] Second, the decision of

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[1] The First, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, Eleventh, and D.C. Circuits have all considered the question presented and have rejected the "make whole" and

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the court below correctly applies this Court's precedents in upholding the sanctity of a written ERISA plan against a request for the courts to re-write it. Lastly, enforcement of the Plan and reimbursement of the benefits it paid was just and reasonable under the circumstances. Accordingly, this Court's review is not warranted.

## I. THERE IS NO CONFLICT AMONG THE LOWER COURTS ON THE QUESTION PRESENTED

The decision of the Eighth Circuit below is consistent with the decisions of all the courts of appeals to address the question presented. The Courts of Appeals for the First,[2] Third,[3] Fourth,[4]

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"pro rata" doctrines in the face of clear plan language requiring full reimbursement. *See infra*, nn.2-11. The Second Circuit has not yet had an opportunity to consider the question.

[2] *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 280 (1st Cir. 2000) ("Where an ERISA plan requires—without qualification—that plan participants reimburse the plan for benefits paid, the plan should not be construed to depend upon an implied contingency such as the 'make whole' doctrine.").

[3] *Bollman Hat Co. v. Root*, 112 F.3d 113, 116-17 (3d Cir. 1997); *Ryan by Capria-Ryan v. Fed. Express Corp.*, 78 F.3d 123, 124 (3d Cir. 1996) (refusing to import "pro rata" doctrine because courts may not "override a subrogation provision in an ERISA-regulated plan on the ground that the plan would be unjustly enriched if it were to be enforced as written").

[4] *Kress v. Food Employers Labor Relations Ass'n*, 391 F.3d 563, 568 (4th Cir. 2004) (rejecting "make whole" doctrine in the face of clear plan language); *Paris v. Iron Workers Trust Fund, Local No. 5 (In re Paris)*, No. 99-1558, 2000 U.S. App. LEXIS 6883, *8-10 (4th Cir. Apr. 17, 2000) (unpublished); *United*

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Fifth,[5] Sixth,[6] Seventh,[7] Ninth,[8] Tenth,[9] Eleventh,[10] and D.C.[11] Circuits *all* agree with the Eighth Circuit

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*McGill Corp. v. Stinnett*, 154 F.3d 168, 173 (4th Cir. 1998) (rejecting "pro rata" limitation on recovery because "the language of the Plan does not qualify the right to reimbursement by reference to the costs associated with recovery" and the court was "bound to enforce the contractual provisions as drafted").

5 *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938, 940 (5th Cir. 1998); *Sunbeam-Oster Co. v. Whitehurst*, 102 F.3d 1368, 1374-76 (5th Cir. . 1996) (unconditional plan provision implies reimbursement "to the full extent" of benefits previously paid, "regardless of [the] source").

6 *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997) (refusing to import "pro rata" doctrine because "federal courts may not apply common law theories to alter the express terms of written benefit plans"); *cf. Copeland Oaks v. Haupt*, 209 F.3d 811, 813 (6th Cir. 2000) (adopting "make whole" doctrine as a default rule in the absence of clear plan language requiring reimbursement).

7 *Admin. Comm. of the Wal-Mart Stores, Inc. v. Varco*, 338 F.3d 680, 692 (7th Cir. 2003) ("[T]he unambiguous language of the Plan obligates her to repay the benefits paid in full without a pro rata deduction for her legal expenses, and thus any so-called enrichment is not unjust."); *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298-99 (7th Cir. 1993) (Posner, J.) (holding that "the make-whole rule is just a principle of interpretation" that "can be overridden by clear language in the plan" and finding no abuse of discretion in plan administrator's interpretation of plan provision as precluding "make whole" doctrine).

8 *Barnes v. Indep. Auto. Dealers Ass'n of Cal. Health & Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995) ("We would not apply the interpretive 'make-whole rule' as a 'gap-filler' if the subrogation clause in the Plan document specifically allowed

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that the "make-whole" and "pro-rata" doctrines do not apply where the clear language of an ERISA plan requires full reimbursement.

Though only the D.C. Circuit and Eighth Circuit below have addressed the question when framed as an interpretation of "appropriate" equitable relief under section 502(a)(3), *see* Pet. App. at 5a-6a; *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 8-9 n.9 (D.C. Cir. 2006), every court of appeals to consider whether the "make whole" or "pro rata" doctrine should trump clear ERISA plan language requiring full reimbursement has answered the question in the negative. Petitioner's attempt to recast the question as one of statutory interpretation does not change

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the Plan the right of first reimbursement out of any recovery [the participant] was able to obtain even if [the participant] were not made whole.").

9 *Alves v. Silverado Foods, Inc.*, 6 Fed. Appx. 694, 703-04 (10th Cir. 2001) (unpublished) (rejecting "make whole" doctrine because the plan clearly required full reimbursement).

10 *Cagle v. Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997) ("As a default rule, the make whole doctrine applies to limit a plan's subrogation rights where an insured has not received compensation for his total loss *and the plan does not explicitly preclude operation of the doctrine.*" (emphasis added)).

11 *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 8-10 & n.9 (D.C. Cir. 2006) (rejecting "make whole" doctrine where plan "unambiguously establishes a plan priority to any third party recovery the beneficiary obtains regardless whether the beneficiary has been made whole by the recovery" and holding that such full reimbursement to the plan, even though the participant has not been "made whole," is "appropriate" under section 502(a)(3) of ERISA).

this fact. Because there is no conflict among the courts of appeals, and in light of their widespread agreement on this issue, this Court's review of the decision below is unwarranted.

## II. THE DECISION OF THE COURT OF APPEALS BELOW IS CORRECT ON THE MERITS

ERISA's "repeatedly emphasized purpose [is] to protect contractually defined benefits." *Russell*, 473 U.S. at 148 (emphasis added). Accordingly, this Court has held that "the private parties, not the Government, control the level of benefits" provided by an ERISA plan. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981); *see also Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) ("ERISA [does not] mandate what kind of benefits employers must provide if they choose to have [an ERISA] plan."); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("ERISA does not create any substantive entitlement to employer-provided health benefits"); *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 277-78 (1st Cir. 2000) ("Since 'one of the primary functions of ERISA is to ensure the integrity of written, bargained-for benefit plans[,]' generally speaking ERISA does not mandate that a covered plan include particular substantive provisions." (alteration in original) (citation omitted)). It is therefore up to the parties to reach an agreement, memorialized in the form of an ERISA plan, as to the precise benefits conferred upon the plan's members in exchange for their payment of premiums. Accordingly, courts uniformly enforce clear plan language. *See, e.g., Admin. Comm. of the Wal-Mart Stores, Inc. v. Varco*, 338 F.3d 680, 691 (7th Cir. 2003); *United McGill Corp. v. Stinnett*, 154

F.3d 168, 172 (4th Cir. 1998) ("[T]he plain language of an ERISA plan must be enforced in accordance with 'its literal and natural meaning.'") (quoting *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997)); *Van Orman v. Am. Ins. Co.*, 680 F.2d 301, 312 (3d Cir. 1982); *cf. Barnes v. Alexander*, 232 U.S. 117, 122-23 (1914) (in a case relied upon in this Court's opinion in *Sereboff*, 126 S. Ct. 1869, rejecting the argument that a payment owed to the payee out of funds received by the payor should be reduced because the payor did not recover the full amount expected, and enforcing the terms of their agreement).

Though this Court has recognized the limited need for federal courts "to develop a federal common law of rights and obligations under ERISA-regulated plans," *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (internal quotations omitted), it has also warned against "tamper[ing] with an enforcement scheme crafted with such evident care as the one in ERISA," *Russell*, 473 U.S. at 147; *cf. Halcyon Lines v. Haenn Ship Ceiling & Refitting Corp.*, 342 U.S. 282, 285 (1952) (refusing to create a rule of federal common law in the heavily regulated area of maritime personal injuries). These two commands do not conflict; courts craft federal common law, but only in the absence of clear plan language. *See United McGill*, 154 F.3d at 171-72. Moreover, enforcing plans as written fulfills the parties' expectations and encourages employers to offer ERISA plans for the benefit of all employees. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (noting the public interest in encouraging the formation of employee benefit plans). For these reasons, federal courts have proceeded with the utmost caution when asked to adopt new rules of

federal common law in the ERISA context, doing so only if necessary to interpret ambiguous ERISA plan language. *See, e.g.*, *Van Orman*, 680 F.2d at 311-13; *Murphy v. Heppenstall Co.*, 635 F.2d 233, 237 (3d Cir. 1980).

Federal courts have therefore repeatedly refused to read the "make whole" doctrine into plans that clearly reject it. *See, e.g.*, *Harris*, 208 F.3d at 280 ("Where an ERISA plan requires—without qualification—that plan participants reimburse the plan for benefits paid, the plan should not be construed to depend upon an implied contingency such as the 'make whole' doctrine."); *Sunbeam-Oster Co. v. Whitehurst*, 102 F.3d 1368, 1374-76 (5th Cir. 1996) (unconditional plan provision implies reimbursement "to the full extent" of benefits previously paid, "regardless of [the] source"); *cf. Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1299 (7th Cir. 1993) (finding no abuse of discretion in plan administrator's interpretation of plan provision as precluding "make whole" doctrine). Similarly, courts have also refused to apply the "pro rata" doctrine where the language of the governing plan clearly dictates full reimbursement. *See, e.g.*, *United McGill*, 154 F.3d at 173 (rejecting "pro rata" limitation on recovery because "the language of the Plan does not qualify the right to reimbursement by reference to the costs associated with recovery" and the court was "bound to enforce the contractual provisions as drafted"); *Isbell*, 139 F.3d at 1072 (refusing to import "pro rata" doctrine because "federal courts may not apply common law theories to alter the express terms of written benefit plans"); *Ryan by Capria-Ryan v. Fed. Express Corp.*, 78 F.3d 123, 124 (3d Cir. 1996) (refusing to import "pro rata" doctrine because courts may not "override a

subrogation provision in an ERISA-regulated plan on the ground that the plan would be unjustly enriched if it were to be enforced as written"); *cf. Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141 (8th Cir. 1997) (agreeing with above authority, but implying "pro rata" offset as a default rule because the plan did not provide otherwise).

In an effort to reopen this settled question, Petitioner attempts to portray it as one of statutory interpretation, arguing that ERISA's requirement that "equitable relief" be "appropriate," § 1132(a)(3), somehow requires courts to impose the "make whole" or "pro rata" doctrine to override clear plan language to the contrary. But framing the question as one of statutory interpretation does not change the answer. In *Sereboff*, this Court held that "equitable relief" under section 502(a)(3) includes equitable restitution in the form of a constructive trust where the ERISA plan seeks "specifically identifiable funds" that are in the participant's control and owed pursuant to the plan. 126 S. Ct. at 1874. Petitioner does not dispute or seek review of the holding of the courts below that the relief granted to the Plan in this case was "equitable" under *Sereboff*. Instead, Petitioner argues that this relief was not "appropriate" under section 502(a)(3). While *Sereboff* declined to address the meaning of "appropriate," 126 S. Ct. at 1877 n.2, this Court's ERISA decisions, which have been interpreted uniformly by eleven courts of appeals to bar application of the "make whole" and "pro rata" doctrines where they contradict clear plan language, preclude Petitioner's claim. Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief' at large, but only 'appropriate equitable relief' for the purpose of . . . 'enforc[ing] any provision[s]' of ERISA or an ERISA plan." *Mertens v. Hewitt Assocs.*, 508

U.S. 248, 253 (1993) (quoting 29 U.S.C. § 1132(a)(3)). Petitioner attempts to import a substantive limitation on ERISA plans into a statutory provision that deals only with the remedies available to enforce such plans. But "appropriate" modifies "equitable relief," and this Court has interpreted this modifier to refer to the *type of relief* available under a plan, not the *substance of the plan*. *See Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996). And it is not the province of the courts to rewrite the substance of ERISA plans. *See Alessi*, 451 U.S. at 511-14; *Ryan*, 78 F.3d at 126.

It is undisputed that the Plan in this case requires 100 percent recovery of benefits paid on Petitioner's behalf after Petitioner obtained a settlement from a third party, not a "pro rata" recovery or one limited by whether Petitioner was "made whole" by the settlement. And Petitioner has never claimed that the Plan is ambiguous. *See* Pet. App. at 22a. Because there is no ambiguity with respect to the Plan's terms, there is no need to consider whether Petitioner's proposed principles of federal common law such as the "make whole" and "pro rata" doctrines should apply.

Despite the Plan's clear language, Petitioner cites this Court's decision in *Boggs v. Boggs*, 520 U.S. 833 (1997), for the proposition that "the principal purpose of ERISA is 'to protect plan participants and beneficiaries.'" Pet. at 12 (quoting *Boggs*, 520 U.S. at 845). But this purpose of ERISA is in no way undermined by the decisions of the court below and the ten other circuits that have rejected attempts to apply the "make whole" or "pro rata" doctrine to override clear plan language to the contrary. Though individual participants and beneficiaries might gain

if a plan's explicit reimbursement requirements are overridden on an ad hoc basis in their cases, a plan's financial viability would be compromised and the rest of the plan's participants and beneficiaries would suffer if such an approach were adopted. *See Harris*, 208 F.3d at 280-81 ("ERISA objectives could be disserved if the 'make whole' doctrine were to be adopted as the ERISA default rule. Although plan members like the Harrises would benefit financially, ultimately the costs would be borne by all other plan members in the form of higher premiums for coverage."); *see also Cutting*, 993 F.2d at 1298 (Posner, J.). Thus, the Committee's decision to enforce the Plan "protect[s] plan participants and beneficiaries," *Boggs*, 520 U.S. at 845, and fulfills the Committee's fiduciary duty to "preserve assets to satisfy future, as well as present, claims and . . . to take impartial account of the interests of all beneficiaries," *Varity Corp.*, 516 U.S. at 514.

Petitioner cites *Arkansas Department of Health and Human Services, et al. v. Ahlborn*, 547 U.S. 268 (2006), in support of her "pro rata" argument. But *Ahlborn's* holding turned on the particulars of federal Medicaid law and is therefore inapposite. *Ahlborn* involved a state law that required Medicaid recipients to reimburse all payments for medical expenses when they obtain third-party judgments or settlements. *Id.* at 277. This Court held that the state law requirement conflicted with federal Medicaid laws, which entitled a state to only the portion of a judgment or settlement representing payment for medical expenses. *Id.* at 278-80, 292. But ERISA imposes no such substantive rule. To the contrary, ERISA provides no minimum amount of benefits and leaves the substance of an ERISA plan up to the contracting parties. *See Curtiss-Wright*,

514 U.S. at 78 ("ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits," nor does it "establish any minimum participation, vesting, or funding requirements for welfare plans as it does for pension plans"). In cases where the employee benefit plan in question provides for pro rata reimbursement, *see, e.g.*, *Springs Valley Bank & Trust Co. v. Carpenter*, 885 F. Supp. 1131, 1143 (S.D. Ind. 1993), such reimbursement is appropriate and should be enforced. But the Plan in this case contains no such limitation. The court of appeals thus correctly rejected Petitioner's "pro rata" argument and upheld the Plan's request for full reimbursement.

Because the decision of the Eighth Circuit below is correct on the merits, review by this Court is unnecessary.

## III. ENFORCEMENT OF THE PLAN'S TERMS AND REIMBURSEMENT OF THE PLAN WAS JUST AND REASONABLE

Though Petitioner had been a Plan member for just over three months before her accident, the Plan paid a substantial amount—$469,216—to cover her medical expenses without any guarantee that it would be reimbursed. In exchange for this substantial benefit, Petitioner paid premiums and promised that she would reimburse the Plan if she obtained a settlement from a third party. "[I]t would be inequitable to permit [Petitioner] to partake of the benefits of the Plan and then, after [Petitioner] had received a substantial settlement, invoke common law principles to establish a legal justification for [Petitioner's] refusal to satisfy [her] end of the bargain." *Ryan*, 78 F.3d at 127-28. "[T]he

unambiguous language of the Plan obligates [Petitioner] to repay the benefits paid in full . . . , and thus any so-called enrichment is not unjust." *Varco*, 338 F.3d at 692; *see also Cummings v. Briggs & Stratton Ret. Plan*, 797 F.2d 383, 390 (7th Cir. 1986) ("Enrichment is not 'unjust' where it is allowed by the express terms of the . . . plan.").

As the Plan's fiduciary, the Committee had an obligation to all the Plan's participants and beneficiaries to enforce the Plan's terms and preserve its assets. *See Varity Corp.*, 516 U.S. at 514 (An ERISA fiduciary has an obligation "to preserve assets to satisfy future, as well as present, claims" and must "take impartial account of the interests of all beneficiaries"); *see also* RESTATEMENT (THIRD) OF TRUSTS § 79 (2007) (discussing a trustee's duty of impartiality).

Because "self-funded ERISA plans generally have very limited resources that they must use for the benefit of all their participants," "[s]ubrogation is an extremely important tool for maintaining the financial viability of such plans." *Paris v. Iron Workers Trust Fund, Local No. 5 (In re Paris)*, No. 99-1558, 2000 U.S. App. LEXIS 6883, *8-9 (4th Cir. Apr. 17, 2000).[12] To preserve assets for other

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[12] ERISA's goal of minimizing the costs to employers of providing welfare benefits, *see Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997), is also furthered by allowing plans to require full reimbursement. *Cf. United States v. Lorenzetti*, 467 U.S. 167, 177 (1984) (Federal Employees Compensation Act's goal of minimizing costs requires employee who receives workers' compensation benefits to use a third-party recovery to repay the government "regardless of whether the third-party recovery

[Footnote continued on next page]

plan members, ERISA fiduciaries must—and routinely do—enforce reimbursement provisions such as the one at issue in this case. Indeed, the wealth of case law in the circuits came about because ERISA plans took legal action to enforce subrogation provisions when plan participants recovered from third parties, just as the Committee did in this case. *See, e.g.*, *Harris*, 208 F.3d at 276 (ERISA administrator filed a lien against a participant's tort recovery); *United McGill*, 154 F.3d at 170 (plan perfected a lien and then sued for declaratory judgment); *Sunbeam-Oster*, 102 F.3d at 1372 (plan filed a civil complaint against a participant).[13]

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[Footnote continued from previous page]
includes compensation for losses other than medical expenses and lost wages").

[13] Full reimbursement is a common practice even in the insurance context, without the primacy ERISA gives to plan language, *Van Orman*, 680 F.2d at 312 ("The Supreme Court has emphasized the primacy of plan provisions . . . ." (citing *Alessi*, 451 U.S. at 511)), and the "make whole" doctrine usually does not apply in the face of clear contract language to the contrary, *see* RUSS ET AL., *supra*, § 223:145; *see also, e.g.*, *Ex parte State Farm Fire & Cas. Co.*, 764 So. 2d 543, 545-46 (Ala. 2000); *Travelers Indem. Co. v. Ingebretsen*, 38 Cal. App. 3d 858, 866 (1974); *Capitol Indem. Corp. v. Strike Zone*, 646 N.E.2d 310, 312 (Ill. App. Ct. 1995); *Willard v. Auto Underwriters, Inc.*, 407 N.E.2d 1192, 1193 (Ind. Ct. App. 1980); *Wine v. Globe Am. Cas. Co.*, 917 S.W.2d 558, 562 (Ky. 1996); *Stancil v. Erie Ins. Co.*, 740 A.2d 46, 46-47 (Md. Spec. Ct. App. 1999); *Westendorf v. Stasson*, 330 N.W.2d 699, 703 (Minn. 1983); *Culver v. Ins. Co. of N. Am.*, 559 A.2d 400, 402 (N.J. 1989); *N. Buckeye Educ. Council Group Health Benefits Plan v. Lawson*, 798 N.E.2d 667, 674 (Ohio Ct. App. 2003); *Ditomasso v. Ocean State Physicians Health Plan, Inc.*, 1988 R.I. Super. LEXIS 52, *5-6 (R.I. Super. Ct. 1988); *Westfield Ins. Co., Inc. v. Rowe*, 631 N.W.2d 175, 180

[Footnote continued on next page]

As the named fiduciary charged with preserving the Plan's assets, the Committee did what was required and, indeed, expected of it under the circumstances. Because full recovery of benefits paid on Petitioner's behalf pursuant to the terms of the Plan was just and reasonable, review of the decision below by this Court is not warranted.

## CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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(S.D. 2001); *Hill v. State Farm Mut. Auto. Ins. Co.*, 765 P.2d 864, 866 (Utah 1988); *Fisher v. Aldi Tire Inc.*, 902 P.2d 166, 168 (Wash. Ct. App. 1995); *Kanawha Valley Radiologists Inc. v. One Valley Bank, N.A.*, 557 S.E.2d 277, 282 (W. Va. 2001).